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STATE OF VERMONT  
DEPARTMENT OF LABOR  
WORKERS' COMPENSATION DIVISION

DOL FORM 28A FY-07 Rev 6/06  
State File No. \_\_\_\_\_  
Ins. Co. File No. \_\_\_\_\_  
Date of Injury \_\_\_\_\_  
Fed. ID No. \_\_\_\_\_  
Social Sec. No. \_\_\_\_\_

NOTICE OF CHANGE IN COMPENSATION RATE  
(for INJURIES BEFORE JULY 1, 1986)

RE: \_\_\_\_\_ v. \_\_\_\_\_  
(Employee) (Employer)

Check type of agreement involved: ☐ Temporary Total ☐ Permanent Total ☐ Fatal  
☐ Temporary Partial ☐ Permanent Partial

- Write in the employee's compensation rate effective June 30, 2006.  
(Not including dependent's benefits.) \$ \_\_\_\_\_
- Multiply line 1 by 1.025 and write in the result, but not more than the maximum rate of \$649 or less than the Minimum of \$325. \$ \_\_\_\_\_
- For Temporary Total Disability cases ONLY, multiply the number of dependents under the age of 21 by \$10 and write in the result. \$ \_\_\_\_\_
- Write in the TOTAL of lines 2 and 3. This is the new compensation rate for the year beginning July 1, 2006. \$ \_\_\_\_\_

Maximum rate is \$649 and the minimum rate is \$325 (not including dependent's benefits) for the year beginning July 1, 2006.

This is an amendment to the original Temporary Total, Temporary Partial, Permanent Partial, Permanent Total, or Fatal agreement.

\_\_\_\_\_  
Insurance Company or Self-Insured

\_\_\_\_\_  
Claims Adjuster's Signature

\_\_\_\_\_  
Commissioner of Labor & Industry/Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Instructions to insurance company or self-insurer: Complete above. Increase the weekly compensation rate beginning July 1, 2006. File **three (3) copies** with the Department of Labor before July 15, 2006. After the change has been approved, provide copies 2 and 3 to the carrier and the claimant.